Date: DRAFT

CRITERIA FOR PRIOR AUTHORIZATION

Appropriate NDC Code
(Item or Procedure Here)

Topical Immunomodulators
(Item or Procedure Here)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drugs will be placed on prior authorization:
Tacrolimus (Protopic®)
Pimecrolimus (Elidel®)

CRITERIA: (Must meet all of the following)

1. Restricted to age 2 and older – **exception:** Protopic® 0.1% restricted to adults only.

2. Documented inadequate response or contraindication to fist line agents as recommended in manufacturer labeling and FDA Public Health Advisory.

Criteria recommended by the Drug Utilization Review Committee

_____	_____
Drug Utilization Review Program Manager	Pharmacy Program Manager, Health Care Policy Division
Date: _____	Date: _____